



# Isolation versus Quarantine in Long-Term Care Facilities

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IOWA DEPARTMENT OF PUBLIC HEALTH

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Hello, this is Chris Barten part of the HAI team at the Iowa Department of Public Health. This is being recorded on October 8, 2021. This video describes isolating and quarantining residents in long-term care facility due to a confirmed COVID-19 infection or exposure. The information contained in this video is based on current best practices and guidelines and is subject to change as more information becomes available.

# Overview

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- ❖ **Definitions**
- ❖ **CDC Quarantine Guidance**
- ❖ **CDC Isolation Guidance**
- ❖ **Summary**
- ❖ **IDPH Contacts**
- ❖ **DIA Contacts**
- ❖ **Visitation & Activities**

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During this video, you will get an overview of quarantining and isolating residents exposed to or infected with COVID-19 in a long-term care facility. This will include:

- the basic definitions of quarantine and isolation,
- Current CDC quarantine guidance for long-term care facilities,
- Current CDC isolation guidance for long-term care facilities,
- A quick summary of the differences,
- Iowa Department of Public Health contacts,
- Iowa Department of Inspection and Appeals contacts, and
- A brief note on visitation and group activities when a facility is in outbreak status.

# General Definitions

❖ **Quarantine** is used when someone might have been exposed to an infectious disease (e.g. *COVID-19*) but it is unclear if they were infected with the disease.

❖ **Isolation** is used when someone is infected with an infectious disease (e.g. *COVID-19*), even if they do not have symptoms.

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The ultimate goal of either a quarantine or isolation is the same, to prevent others from becoming exposed to a pathogen and potentially becoming sick. However, the reason why someone is placed in one versus the other is different.

Quarantine is used when someone might have been exposed to an infectious disease (such as *COVID-19*) but it is not clear if they were infected with *COVID-19*. So in the instance of a quarantine you do not know if that person is sick or infectious but there is the possibility that they could become so anytime during the incubation period. Therefore they are separated from others for close monitoring with the goal of quickly identifying illness if it develops plus limit further spread.

Isolation is used when someone is infected with an infectious disease (such as *COVID-19*), even if they do not have symptoms. This is determined by a positive test result. So in the instance of an isolation you know the person has *COVID-19* and at some point will shed virus from their body into their surroundings. Therefore they are isolated from others to help ensure no one comes into contact with virus they are shedding.

A properly implemented infection prevention and control protocol includes applying

**Standard Precautions** for all residents at all times in the facility and **Transmission-Based Precautions** for those residents under quarantine or isolation.

# General Definitions Cont.

❖ **Cohorting** is an infection prevention and control strategy that includes physical and procedural controls to separate infectious residents and decrease risk of transmission to uninfected residents.

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But before we get into the specifics of quarantine and isolation, let's define cohorting. In general cohort means a group of people who share a characteristic but more specifically, when speaking of infection prevention and control, cohorting refers to a strategy that includes physical and procedural controls to separate infectious residents and decrease risk of transmission to uninfected residents. Cohorts can be created based on clinical diagnosis, microbiologic confirmation when available, epidemiology, and mode of transmission of the infectious agent.

When developing quarantine and isolation protocols for a long-term care facility, plan on cohorting residents together who are presumed to have the same infection based on their clinical presentation and diagnosis when known. These residents with the same diagnosis should be cohorted in areas of the facility that are away from other residents, especially residents who are at increased risk for infection (such as those that are immunocompromised). This principle applies to any infectious disease such as a multi-drug resistant organisms, influenza, and the purpose of this video, COVID-19.

When establishing COVID-19 quarantine and isolation protocols, cohorting positive residents who test positive together in a single area allows dedicated staff to work

with only COVID-19-positive residents and helps prevent spreading the virus from infected to uninfected residents

Cohorting also allows staff to adjust the use of personal protective equipment based on the “zone” and helps prevent the confusion that would result from altering PPE strategies on a room-by-room basis compared to a unit-by-unit basis.

Furthermore, cohorting healthcare personnel to care only for residents infected or colonized with a single target pathogen limits further transmission of the target pathogen to uninfected residents. Cohorting healthcare personnel and staff can be based on the unit where they work or their shift, and can help alleviate staffing issues by limiting potential exposures between personnel.

# Quarantine

❖ **Unvaccinated residents** who have had close contact with someone with COVID-19 should be placed in quarantine for 14 days after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (*gowns, gloves, eye protection, and N95 or higher-level respirator*).

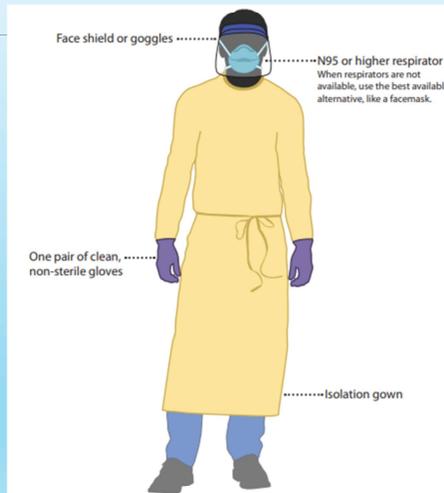
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Unvaccinated residents who have had close contact with someone with COVID-19 infection should be placed in quarantine for 14 days after their exposure, even if viral testing is negative. Ideally, these residents should be moved to a single-person room with a private bathroom. In general, it is recommended that the door to the room remain closed to reduce potential COVID-19 transmission. However, in some circumstances (such as memory care units), keeping the door closed may pose resident safety risks and the door might need to remain open. If doors must remain open, work with facility engineers to implement strategies to minimize airflow into the hallway.

In general, all unvaccinated residents who are new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission.

# Quarantine



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Healthcare personnel caring for unvaccinated residents undergoing quarantine or symptomatic residents undergoing quarantine should use transmission-based precautions during all patient care encounters. This includes an isolation gown, clean gloves, eye protection (such as goggles or a face shield that covers the front and sides of the face), and ideally a N95 or higher level respirator.

While not preferred, it is acceptable to use a facemask if an N95 is not available. **But this should only be considered when N95s are not readily available.**

Although not preferred for healthcare settings, options for shortening quarantine are available. This includes ending quarantines after Day 10 without testing and if **no symptoms** have been noted during any point during the quarantine period. Or ending quarantines after Day 7 if a diagnostic specimen that was collected within 48 hours before the time of planned quarantine discontinuation tests negative and **no symptoms** have been noted during any point during the quarantine period.

# Quarantine

❖ **Fully vaccinated residents** who have had close contact with someone with COVID-19 should wear source control and be tested for COVID-19. Fully vaccinated residents and residents with COVID-19 in the last 90 days do not need to be quarantined, restricted to their room, or cared for by HCP using the full PPE recommended for the care of a resident with COVID-19 infection unless:

▶ they develop symptoms of COVID-19,

**OR**

▶ are diagnosed with SARS-CoV-2 infection.

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Fully vaccinated residents who have had close contact with someone with COVID-19 should wear source control and be tested. If the fully vaccinated resident has never before had COVID-19 they should be tested no sooner than 2 days after exposure and, **if negative**, again 5–7 days after the potential exposure. If the fully vaccinated resident has had COVID-19 within the last 90 days and remains symptom free, testing is not recommended. Other potential exceptions are described in CDC’s ‘Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 Pandemic’ that can be found online.

Fully vaccinated residents and residents with COVID-19 in the last 90 days do not need to be quarantined, restricted to their room, or cared for by healthcare personnel using the full personal protective equipment recommended for the care of a resident with COVID-19 unless **they develop symptoms of COVID-19**, are diagnosed with COVID-19.

# Quarantine

- ❖ Quarantine is not recommended for unvaccinated residents who leave the facility for **less than 24 hours** (*e.g., for medical appointments, community outings with family or friends*) and do not have close contact with someone with COVID-19.
  - ▶ Quarantining residents who regularly leave the facility for medical appointments (*e.g., dialysis, chemotherapy*) would result in indefinite isolation of the resident that likely outweighs any potential benefits of quarantine.

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In most circumstances, quarantine is not recommended for unvaccinated residents who leave the facility for less than 24 hours for medical appointments, community outings with family or friends, or other outings, and do not have close contact with someone known to have COVID-19. Quarantining residents who regularly leave the facility for medical appointments would result in indefinite isolation of the resident that likely outweighs any potential benefits of quarantine.

Unvaccinated residents who leave the facility for 24 hours or longer, in general should be placed in a 14-day quarantine, even if they have a negative test upon their return. Facilities located in counties with low community transmission might elect to use a risk-based approach for determining which unvaccinated residents require quarantine upon admission. However, decisions should be based on whether the resident had known close contact with someone with COVID-19 while outside the facility and if there was consistent adherence to infection prevention and control practices in healthcare settings, during transportation, or in the community prior to admission.

# Isolation

## ❖ Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with Confirmed COVID-19 Infection.

- ▶ The location should ideally be **physically separated** from other rooms or units housing residents without confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.

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Residents should only be placed in a COVID-19 care unit if they have confirmed COVID-19 through a diagnostic test result. When a resident is known to have COVID-19 they should be placed in isolation. Prior to experiencing the first case of COVID-19, identify space in the long-term care facility that could be dedicated to monitor and care for residents with confirmed infection and create a staffing plan for the dedicated space.

The location of the COVID-19 care unit should ideally be physically separated from other rooms or units housing residents without confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility, or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.

In general, it is recommended that the door to the room remain closed to reduce potential COVID-19 transmission. However, in some circumstances (such as memory care units), keeping the door closed may pose resident safety risks and the door might need to remain open. If doors must remain open, work with facility engineers to implement strategies to minimize airflow into the hallway.

# Isolation

- ❖ Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents.
- ❖ If possible, **HCP should avoid working on both the COVID-19 care unit and other units during the same shift.**

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Identify healthcare personnel who will be assigned to work only on the COVID-19 care unit when it is in use. At a minimum this should include the primary nursing assistants and nurses assigned to care for these residents. And if possible, healthcare personnel should avoid working on both the COVID-19 care unit and other units during the same shift.

Furthermore, to the extent possible, restrict access of ancillary personnel (such as dietary staff) to the unit. Ideally, environmental services staff should be dedicated to this unit, but to the extent possible, environmental services staff should avoid working on both the COVID-19 care unit and other units during the same shift.

Dedicated medical equipment should be used when caring for residents with known or suspected COVID. Non-dedicated, non-disposable equipment should be cleaned and disinfected according to manufacturer's instructions and your policy. And remember your policy should ensure that environmental cleaning and disinfection are followed accordingly.

Lastly, to the extent possible, healthcare personnel dedicated to the COVID-19 care unit (such as nurses assistants and nurses) should perform cleaning and disinfection

of high-touch surfaces and shared equipment when in the room for resident care activities. Healthcare personnel should bring an EPA-registered disinfectant (such as wipes) from List N into the room and wipe down high-touch surfaces (such as the light switch, doorknob, and bedside table) before leaving the room.

# EPA List N

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❖ Disinfectants for Coronavirus (COVID-19)

<https://www.epa.gov/coronavirus/about-list-n-disinfectants-coronavirus-covid-19-0>

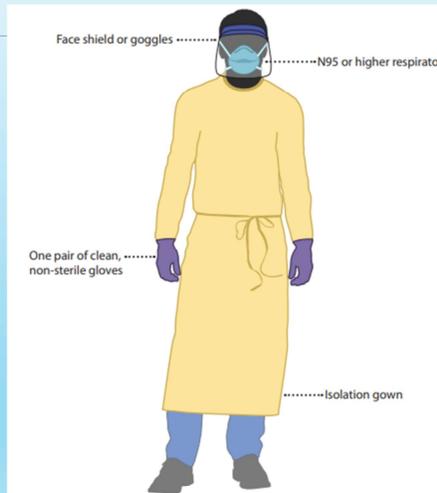
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The EPA List N of disinfectants for COVID-19 can be reviewed by using the URL displayed on this slide or by typing “EPA List N” into a internet search engine.

Please note that all disinfectants on the EPA List N are intended for surfaces only and not medical devices. For proper protocols on disinfecting medical devices refer to the FDA.

# Isolation



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Healthcare personnel caring for residents in isolation should use transmission-based precautions during all patient care encounters. This includes an isolation gown, clean gloves, eye protection (such as goggles or a face shield that covers the front and sides of the face), and a NIOSH-approved N95 or higher level-respirator.

# Isolation

- ❖ A symptom-based strategy for discontinuing Transmission-Based Precautions is preferred in most clinical situations.
- ❖ In general, isolation should last 10 days.

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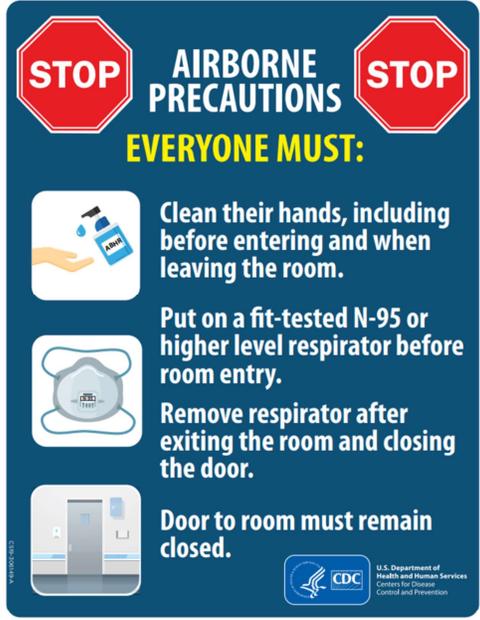
When determining when an isolation period should end a symptom-based strategy for discontinuing Transmission-Based Precautions is preferred in long-term care settings. Criteria for discontinuation are based on the symptoms and immunocompetency of each resident placed in isolation.

- Residents with [mild to moderate illness](#) who are *not* moderately to [severely immunocompromised](#) should remain in isolation until:
  - At least 10 days have passed *since symptoms first appeared* **and**
  - At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
  - Symptoms (such as cough and/or shortness of breath) have improved.
- Residents who were asymptomatic throughout their infection and are *not* [moderately to severely immunocompromised](#) should remain in isolation until:
  - At least 10 days have passed since the date of their first positive viral diagnostic test.
- Residents with [severe to critical illness](#) or who are [moderately to severely](#)

[immunocompromised](#) should remain in isolation until:

- At least 10 days and up to 20 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications **and**
- Symptoms (such as cough and/or shortness of breath) have improved

In the instance of a resident who is moderately to severely immunocompromised consider consultation with infection control experts to determine the exact isolation length. A test-based strategy could also be considered for residents who are moderately to severely immunocompromised and is discussed in further detail in the CDC guidance titled 'Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 Pandemic' available on the CDC website.



The sign is a dark blue rectangle with two red octagonal 'STOP' signs at the top corners. The text 'AIRBORNE PRECAUTIONS' is centered at the top in white. Below it, 'EVERYONE MUST:' is written in yellow. The sign lists four instructions, each with an icon: 1. Handwashing icon with text 'Clean their hands, including before entering and when leaving the room.' 2. N-95 respirator icon with text 'Put on a fit-tested N-95 or higher level respirator before room entry.' 3. Removing respirator icon with text 'Remove respirator after exiting the room and closing the door.' 4. Closed door icon with text 'Door to room must remain closed.' At the bottom right of the sign is the CDC logo and 'U.S. Department of Health and Human Services Centers for Disease Control and Prevention'. A vertical copyright notice '© 2014 CDC' is on the left side.

<https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html>

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Post visual alerts (such as signs, posters) at the entrance and in strategic places (such as waiting areas, elevators, cafeterias) with instructions about current infection prevention and control recommendations. Dating these alerts can help ensure people know that they reflect current recommendations.

This is especially true in areas where residents are on transmission-based precautions.

An example of a sign for when a resident is placed on airborne precautions is displayed on this slide and other examples can be found at the URL displayed or by typing “CDC Transmission-Based Precautions” into an internet search engine.

# Summary

Quarantine	Isolation
Exposed, unknown or pending test results	Confirmed, positive test result
Unvaccinated (or vaccinated symptomatic)	Unvaccinated or Vaccinated
Cohort together (separate from isolated residents)	Cohort together (separate from quarantined residents)
Transmission-Based Precautions	
Visual alerts	
14 days	Minimum 10 days

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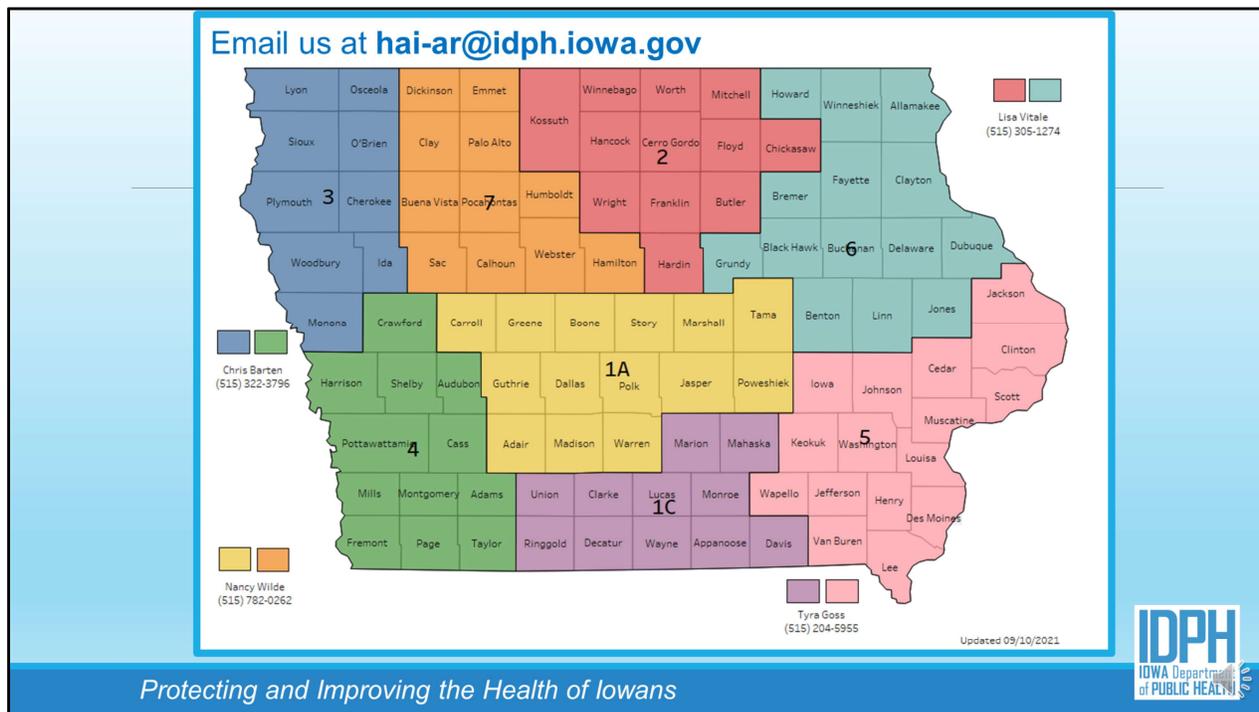
To summarize quarantines are for those residents that were potentially exposed to COVID-19 but it is not yet known if they are infected whereas isolation is for residents that are known to be infected with COVID-19.

Long-term care facilities should have quarantine protocols for potentially exposed residents that are unvaccinated for COVID-19 or are displaying symptoms consistent with COVID-19, regardless of their vaccination status. Isolation is appropriate for **only** those residents that are known to be infected with COVID-19. And whenever possible, quarantined residents should be cohorted separately from isolated residents.

When interacting with residents in either quarantine or isolation healthcare workers should use transmission-based precautions and all appropriate PPE that entails. And visual alerts should be used to quickly inform anyone entering a room or zone of the proper PPE to use.

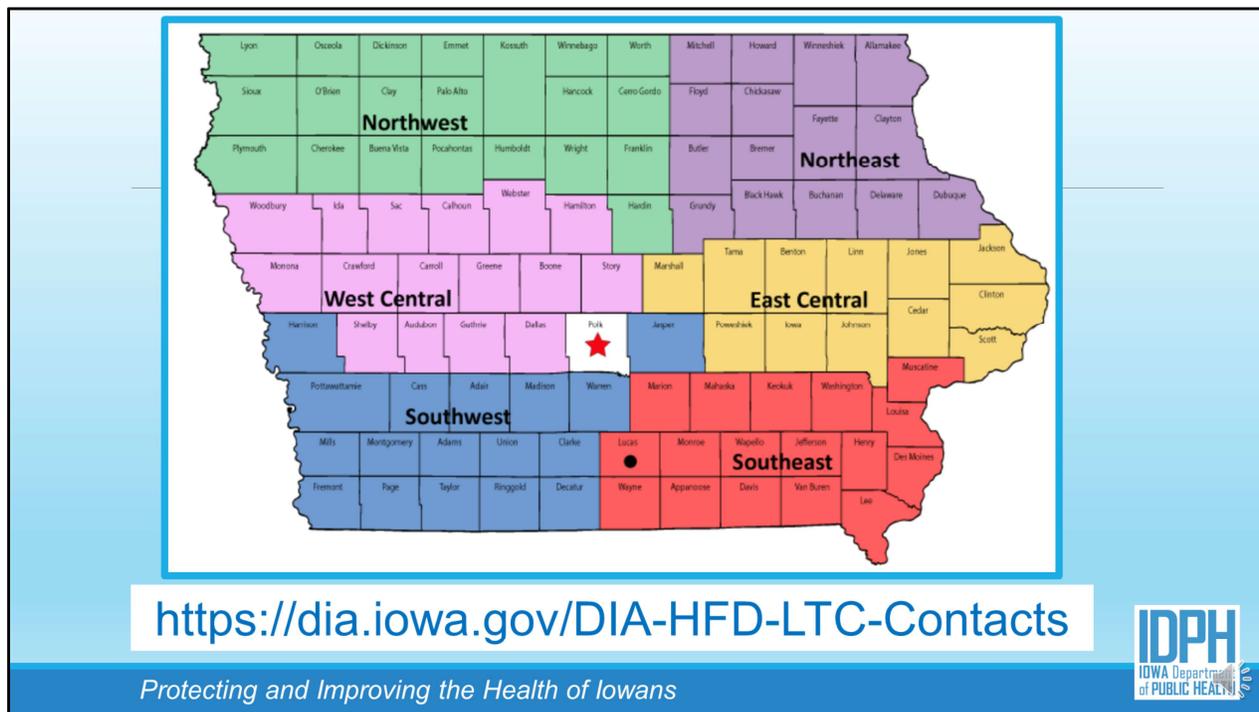
Lastly, in general, quarantines last for 14 days whereas isolations last for at least 10 days.

This slide and the table displayed are meant to serve as a high level summary and more specific details were covered earlier in this video.



And now for a few final comments.

For further questions or technical assistance regarding quarantine and isolation protocols in a long-term care facility you can reach out to the regional nurse clinician covering your area. The map on this slide displays the specific point-of-contact based on the county where your facility is located. You can contact your regional nurse clinician directly or send an email to [hai-ar@idph.iowa.gov](mailto:hai-ar@idph.iowa.gov).



As a reminder, the Iowa Department of Public Health is not a regulatory agency. Instead the HAI Team at the Iowa Department of Public Health is here to provide you with technical assistance.

Regulatory questions should be directed to the Iowa Department of Inspections and Appeals contact for your area. A map of the DIA coverage areas is included on this slide and the contact information for the corresponding program manager and bureau chief can be found at the URL displayed.

Questions that should be directed to your DIA contact and not your Iowa Department of Public Health Regional Nurse Clinician include but are not limited to:

- The appropriate frequency of COVID-19 surveillance testing for both staff and residents,
- Non-conventional PPE use due to supply shortages,
- Issues with staff-to-resident ratios, and
- Implementing quarantine policies more conservative than current CDC guidance.

# Visitation & Activities

- ❖ Facilities should follow guidance outlined in the m CMS Memo **QSO-20-39-NH** about visitation.
- ❖ Pause group activities when COVID-19 is detected.

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This video will end with a brief explanation on visitation policies and group activity policies during a COVID-19 outbreak. The information covered on this slide is not meant to be comprehensive and when finalizing visitation and group activity policies you should consult with your DIA point-of-contact highlighted on the previous slide.

In general visitors should be counseled about their potential to be exposed to COVID-19 while in the facility and source control and physical distancing recommendations should also be followed for vaccinated residents.

When COVID-19 is identified in a long-term care facility, group activities should pause until one round of facility-wide testing can be completed and the overall status of the facility can be evaluated to determine what units are involved. While a facility is experiencing COVID-19 cases unvaccinated residents should generally be restricted to their rooms, even if testing is negative, and cared for by healthcare personnel using an N95 or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities.

Any questions regarding the regulatory enforcement of visitation policies or group

activity policies should be directed to your DIA point-of-contact.

This concludes this video summarizing the quarantine and isolation in long-term care settings.